

PLEASE PRINT USING A BALLPOINT PEN. PRESS FIRMLY; THE LAST COPY IS YOURS.

SOCIAL SECURITY #		E-MAIL		TYPE OF FORM <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> NEW HIRE <input type="checkbox"/> TRANSFER <input type="checkbox"/> CHANGE IN STATUS			
LAST NAME			FIRST NAME			MI	
HOME ADDRESS (STREET)			CITY		STATE	ZIP	HOME PHONE
BIRTH DATE / /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	DATE EMPLOYED / /		EFFECTIVE DATE		OFFICE PHONE

INSTRUCTIONS

RETURN COMPLETED FORM TO YOUR BENEFITS COORDINATOR NO LATER THAN MAY 15, 2015.

WHO NEEDS TO COMPLETE AN ENROLLMENT FORM?

- New participants who want to enroll for the first time
- Employees who want to add, change or cancel coverage of other benefits
- **EXISTING BENEFITS NOT INDICATED ON THIS FORM WILL CONTINUE AS CURRENTLY ENROLLED.**

HOW TO ENROLL IN THE MOUNTAINEER FLEXIBLE BENEFITS PLAN:

- **IMPORTANT:** If you want to add, change or cancel coverage, **you must check the box beside the appropriate benefit** in Section 3. Indicate coverage levels and any other pertinent information.
- If you select family coverage for any benefit, you must provide dependent information in Section 4.

CHANGE IN STATUS

- Include supporting documentation.
- Must be requested within 60 days of status changing event.
- List all dependents you want covered.

Mountaineer Flexible Benefits Tax-Free Benefits Paid by Employees

 IF YOU ENROLL IN A HEALTH SAVINGS ACCOUNT, YOU CANNOT ENROLL IN A MEDICAL SPENDING ACCOUNT, BUT MAY ENROLL IN A LIMITED-USE MEDICAL SPENDING ACCOUNT.

KEEP COVERAGE	ADD COVERAGE	CHANGE COVERAGE	CANCEL COVERAGE	BENEFITS			COST PER PAY PERIOD						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>DELTA DENTAL</b> <input type="checkbox"/> Routine <input type="checkbox"/> Assistance <input type="checkbox"/> Basic <input type="checkbox"/> Enhanced		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family	If you select dependent coverage for dental, vision or hearing, you must complete the dependent information below.						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>VISION</b> CHOOSE ONE VISION OPTION: <input type="checkbox"/> Exam Plus <input type="checkbox"/> Full Service		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Family							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>EPIC HEARING SERVICE PLAN</b>		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>LONG-TERM DISABILITY INCOME PLAN</b> <b>Employee Only</b>			<input type="checkbox"/> 50% of salary coverage <input type="checkbox"/> 70% of salary coverage						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>SHORT-TERM DISABILITY INCOME PLAN</b> <b>Employee Only</b>									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>MEDICAL EXPENSE FLEXIBLE SPENDING ACCOUNT</b> Use cost per-pay-period from your Worksheet. ALL CLAIMS MUST BE SUBMITTED BY OCTOBER 31, 2016.									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT</b> Use cost per-pay-period from your Worksheet. <input type="checkbox"/> Married, filing separately <input type="checkbox"/> Married, filing jointly <input type="checkbox"/> Single, head of household    ALL CLAIMS MUST BE SUBMITTED BY OCTOBER 31, 2016.									
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<b>LEGAL (POST-TAX)</b>									
HEALTH SAVINGS ACCOUNT   (Additional forms required.)				LIMITED-USE MEDICAL EXPENSE FSA			SUBTOTAL	COST PER PAY PERIOD					
<table><tr><th>KEEP COVERAGE</th><th>ADD COVERAGE</th><th>CHANGE COVERAGE</th><th>CANCEL COVERAGE</th></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr></table>	KEEP COVERAGE	ADD COVERAGE	CHANGE COVERAGE	CANCEL COVERAGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<b>Select your HSA coverage type:</b> <input type="checkbox"/> Individual (\$3,350 maximum 2016 PY) <input type="checkbox"/> Family (\$6,550 maximum 2016 PY) <input type="checkbox"/> Over 55 Catch-up (additional maximum \$1,000)			
KEEP COVERAGE	ADD COVERAGE	CHANGE COVERAGE	CANCEL COVERAGE										
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
Box #1 2016 Plan Year Total Dollar Amount				Box #1 2016 Plan Year Total Dollar Amount			HSA						
Box #2 Number of Pay Periods      ÷				Box #2 Number of Pay Periods      ÷			Limited-Use Medical Expense FSA						
Box #3 Reduction Per Regular Pay Period      =				Box #3 Reduction Per Regular Pay Period      =			SUBTOTAL						
				<b>TOTAL SALARY DEDUCTION AMOUNT PER PAY PERIOD</b>									

DEPENDENT INFORMATION

USE AN ADDITIONAL SHEET OF PAPER AS NEEDED FOR ADDITIONAL DEPENDENTS.

DEPENDENT NAME	RELATIONSHIP	MALE/ FEMALE	BIRTH DATE	SOCIAL SECURITY #	CHECK COVERAGE SELECTED			
					DENTAL	VISION	HEARING	LEGAL
	SPOUSE							

I hereby authorize my Employer to reduce my gross salary (before federal and state income and Social Security taxes are calculated) by the total per pay period cost of my Flexible Benefits. I understand that I CANNOT CHANGE THE AMOUNT OF THE REDUCTION OR REVOKE THIS AGREEMENT DURING THE PLAN YEAR UNLESS THERE IS A CHANGE IN STATUS AS DEFINED BY IRS RULES. I further understand that any amount remaining in my Flexible Spending Accounts that is not used during this plan year and grace period CANNOT BE ACCUMULATED AND CARRIED FORWARD TO THE NEXT PLAN YEAR BUT WILL REVERT TO THE PLAN.

The Premium Deduction "total salary deduction" amount specified above will continue in effect until I discontinue or modify my Agreement for a subsequent plan year, terminate employment, or take an unpaid leave of absence from employment. I UNDERSTAND AND AGREE THAT PEIA AND FBMC BENEFITS MANAGEMENT INC., THE CONTRACT ADMINISTRATOR, WILL BE HELD HARMLESS FROM ANY LIABILITY RESULTING FROM EITHER MY PARTICIPATION IN MOUNTAINEER FLEXIBLE BENEFITS OR MY FAILURE TO SIGN OR ACCURATELY COMPLETE THIS ENROLLMENT FORM. I hereby appoint my Plan Sponsor to serve as Agent to receive dividends, premiums, refunds, rate reductions or any other funds that might be returned from the benefit plans, and to use these funds in the best interest of the employees for the purpose of reducing future premiums and improving benefits on behalf of employees, defraying administrative costs, or for such other purpose as permitted under applicable state and federal law.

DURING OPEN ENROLLMENT TURN COMPLETED FORMS INTO YOUR BENEFITS COORDINATOR NO LATER THAN MAY 15, 2015.

FOR BENEFITS COORDINATOR USE ONLY (COMPLETE IN FULL)

FEIN# \_\_\_\_\_

AGENCY NAME \_\_\_\_\_

4 DIGIT WORK LOCATION # \_\_\_\_\_      EFFECTIVE DATE \_\_\_\_\_

NO. PAY DEDUCTIONS \_\_\_\_\_

GROSS ANNUAL SALARY \_\_\_\_\_

BENEFIT COORDINATOR SIGNATURE \_\_\_\_\_

BENEFIT COORDINATOR PHONE# (        ) \_\_\_\_\_

BENEFIT COORDINATOR FAX# (        ) \_\_\_\_\_

LOCATION TYPE:   ☐ STATE AGENCIES                                      ☐ UNIVERSITIES & COLLEGES  
                                 ☐ COUNTY BOARDS OF EDUCATION                      ☐ NON-STATE AGENCIES

APPLICATIONS SHOULD BE MAILED TO FBMC TWICE EACH WEEK DURING OPEN ENROLLMENT. MUST BE POSTMARKED BY MAY 22, 2015.

EMPLOYEE SIGNATURE	DATE SIGNED	TIME SIGNED
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FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES
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